



West Virginia

EPI-LOG

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New state law allows for quicker, easier STD treatment for sex partners

On February 25, 2016, Governor Earl Ray Tomblin signed Senate Bill 123 into law, allowing expedited partner therapy in West Virginia. Expedited Partner Therapy (EPT) is the clinical practice of treating the sexual partners of patients diagnosed with chlamydia or gonorrhea by providing a prescription or dispensing medications to the patient to take to his or her partner without the healthcare provider first examining the partner.¹ The purpose of EPT is to decrease the rate of reinfection and transmission to other partners. Expedited treatment has been found to be more effective than the standard referral of partners in reducing persistent or recurrent infections among patients with gonorrhea and chlamydia, and it is associated with a reduced risk of persistent or recurrent infection after adjustment for other predictors of infection at follow-up.² Providing EPT is at the discretion of the health care professional who makes a clinical diagnosis of gonorrhea or chlamydia and may provide appropriate antibiotic treatment for a sex partner if he or she is unlikely or unable to present for comprehensive health care.³ The intent of EPT is not to discourage patients with potential exposure to STDs from seeking medical care including diagnostic evaluation, counselling and treatment. EPT is limited to a sexual partner who may have been exposed to gonorrhea or chlamydia by the diagnosed patient within the previous sixty days and who is able to be contacted by the infected patient.⁴



(See **EPT**, page 2)

Statewide Disease Facts & Comparisons

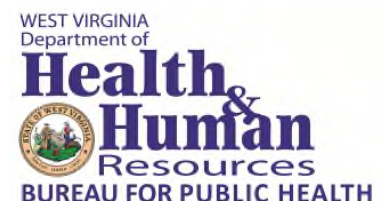
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IN THIS ISSUE:

- Expedited Partner Therapy (EPT)
- Plotting strategies against tuberculosis
- Immunization Summit in June
- Zika Q&A
- 1st quarter 2016 Outbreak Report

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Earl Ray Tomblin, Governor
Karen L. Bowling, Cabinet Secretary
Dr. Rahul Gupta, Commissioner and
State Health Officer

(EPT, continued from page 1)

A healthcare professional who provides expedited partner therapy should provide counseling for the patient and partner(s), including advice that all women, especially those with symptoms of pelvic inflammatory disease, seek immediate medical attention. The health care professional will also provide educational materials to be given by the patient to his or her sex partner.⁵ The CDC recommends when medication or prescriptions provided for the partners of patients with gonorrhea or chlamydial infection should be accompanied by treatment instructions, appropriate warnings about taking medications, including advice that if the partner is pregnant they seek medical attention and advise patients to ask partners about potential allergy to the medications used in EPT.⁶

The CDC strongly recommends that a partner's prescription or medication should be accompanied by information containing treatment instructions with appropriate warnings about possible side effects and allergic reactions and a statement advising that the partner should seek personal medical evaluation, particularly women who are pregnant and individuals experiencing STD symptoms. Also, partners should be instructed where they may receive care if they are uninsured, such as a local health department or STD clinic.

Healthcare providers are not subject to civil or professional liability in connection with the provision of the

EPT treatment, counseling and materials, except in the case of gross negligence or willful and wanton misconduct. A healthcare professional is not subject to civil or professional liability for choosing not to provide EPT. Also, they are not liable if they treat sexual partners in good faith, without fee or compensation, as long as they will also provide counseling and written materials as required by law.⁷

To avoid reinfection, sex partners should be instructed to abstain from unprotected sexual intercourse for 7 days after they and their sexual partner(s) have completed treatment and after resolution of symptoms, if present.⁸

The West Virginia Department of Health and Human Resources (WVDHHR) will provide updated information to its website and has developed materials for healthcare providers.

References:

- ¹ <http://www.cdc.gov/std/ept>
- ² SB 123: <https://legiscan.com/WV/text/SB123/id/1339335>
- ³ WV §16-4F, Chapter 16, Public Health, Article 4F
- ⁴ WV §16-4F-2c, Chapter 16, Public Health, Article 4F, 2c
- ⁵ <http://www.cdc.gov/std/tg2015/tg-2015>
- ⁶ SB 123: <https://legiscan.com/WV/text/SB123>
- ⁷ WV §16-4F-3c, Chapter 16, Public Health, Article 4F, 3c
- ⁸ MMWR Recommendations Reports/Vol. 64/No. 3: STD Treatment Guidelines, 2015 ☒

National Tuberculosis Controllers Association shares research and strategies

The National Tuberculosis (TB) Controllers Association held its annual meeting on February 24-27 in Denver, Colorado, in conjunction with The International Union Against Tuberculosis and Lung Disease, North America

Region. The agenda included wide-ranging clinical, scientific and programmatic topics, with particular focus given to pediatric tuberculosis, drug-resistant TB, TB genomics in public health practice and exploring various present day social issues, such as the migration of unaccompanied minors and homelessness. Training was also held during the conference for TB survivors to help them learn to share their stories and organize their efforts as advocates for resources to fight and eliminate TB! ☒



National Tuberculosis Controllers Association

West Virginia
Immunization Network

Loan Fund

Healthy
Future

Immunization Summit to be held in Charleston

The West Virginia Immunization Network (WIN) is sponsoring the Seventh Annual West Virginia Immunization Summit to be held June 21 and 22, 2016, at the Charleston Civic Center in Charleston, West Virginia. The Summit will be held in partnership with the West Virginia Department of Education's KidStrong Conference.

This will be an action-oriented event targeting a wide variety of both public and private organizations with an interest in addressing and resolving immunization issues in West Virginia. Various sessions at the Summit will target healthcare and public health professionals, school nurses and administrators, business leaders, consumers, and others interested in protecting West Virginians from vaccine-preventable diseases. The Immunization Summit convenes each year to coordinate and collaborate on immunization activities throughout West Virginia.

Issues to be addressed at the Summit include the following:

- Improving immunization rates in rural communities
- Childhood immunization
- Health literacy
- Adolescent immunization
- HPV and related cancers
- Pneumococcal vaccination
- Adult immunization
- Evidence-based strategies for improving immunization rates

Each year more than 250 representatives from hospitals, community health centers, school-based health centers, local health departments, pharmacies, private physicians' offices, universities and colleges, primary and secondary schools, businesses and others concerned with improving the health of West Virginians by protecting them from the consequences of vaccine-preventable diseases attend the Summit. Attendees in the exhibit hall will also include those from the KidStrong Conference, which is expected to have an additional 1,000 attendees.

WIN is a statewide immunization coalition with more than 300 members who work to foster sustainable state and community programs to increase immunization rates in West Virginia. This annual Immunization Summit provides an opportunity for individuals from a variety of fields to focus on strategies for protecting West Virginians from vaccine-preventable diseases in West Virginia.

For more information on the summit, go to <http://wvruralhealth.org/WIN/MHCP/TrainingAndEvents/ImmunizationSummit>. ☒



Zika virus:

What you need to know

In 1947, Zika virus, the causative agent for Zika virus disease, a flavivirus, was first described from a sentinel rhesus monkey in Uganda. The monkey was part of a study searching for yellow fever and this monkey was living in a cage in the Zika forest in Uganda. Symptoms of Zika virus infection include fever, rash, joint pain, conjunctivitis (redness of eyes), muscle aches, and headache. Most individuals (80%) infected with the Zika virus do not develop symptoms. The symptoms of Zika virus disease are mild and hospitalization and death are rare in human Zika virus disease cases.

Prior to 2007, human cases were sporadically reported from Africa and Southeast Asia. The first reported outbreak of Zika virus disease occurred in 2007 on Yap Island near Southeast Asia, where 73% of the residents became infected with Zika virus. In 2013, greater than 28,000 human cases of Zika virus disease were documented in French Polynesia. Starting in 2014, numerous Zika virus disease human cases have occurred in Central America, South America, and the Caribbean. Since the symptoms of this disease are very similar to other diseases from these localities, such as chikungunya and dengue, the prevalence of Zika virus disease may have been underreported before 2007. Furthermore, serological antibody laboratory tests cannot differentiate between Zika virus infection and infection with other flaviviruses, such as dengue virus, yellow fever virus, Japanese encephalitis virus, and West Nile virus.

Although Zika virus disease is an arboviral disease transmitted predominantly by *Aedes* mosquitoes, there are additional modes of Zika virus transmission to humans. There have been multiple reports of blood transfusion transmission cases in Brazil. In French Polynesia, 2.8% of the blood donors were positive for Zika virus. Zika virus can be spread by a human male to his sexual partners. The virus can be transmitted sexually before, during, and after symptoms onset. Zika virus remains in the semen longer than in the blood. Although a pregnant woman can pass Zika virus to her fetus during pregnancy, there have been no reports of transmission from mother to offspring through breastfeeding.

Although the Zika virus disease is usually characterized by short duration and limited severity, there is the potential for serious neurological complications. There is an association between Zika virus disease and Guillain-Barré syndrome, an autoimmune response whereby the host's immunity system preferentially attacks its own peripheral nerves in the legs, arms, hands, and face. Zika virus infection of the fetus during pregnancy can cause birth defects, including microcephaly and intracranial calcifications in the developing newborn.

Zika virus disease infections have spread rapidly throughout the Americas due to human travel and distribution of competent mosquito vectors. During the

(See **Zika**, page 5)



Aedes albopictus



Aedes aegypti

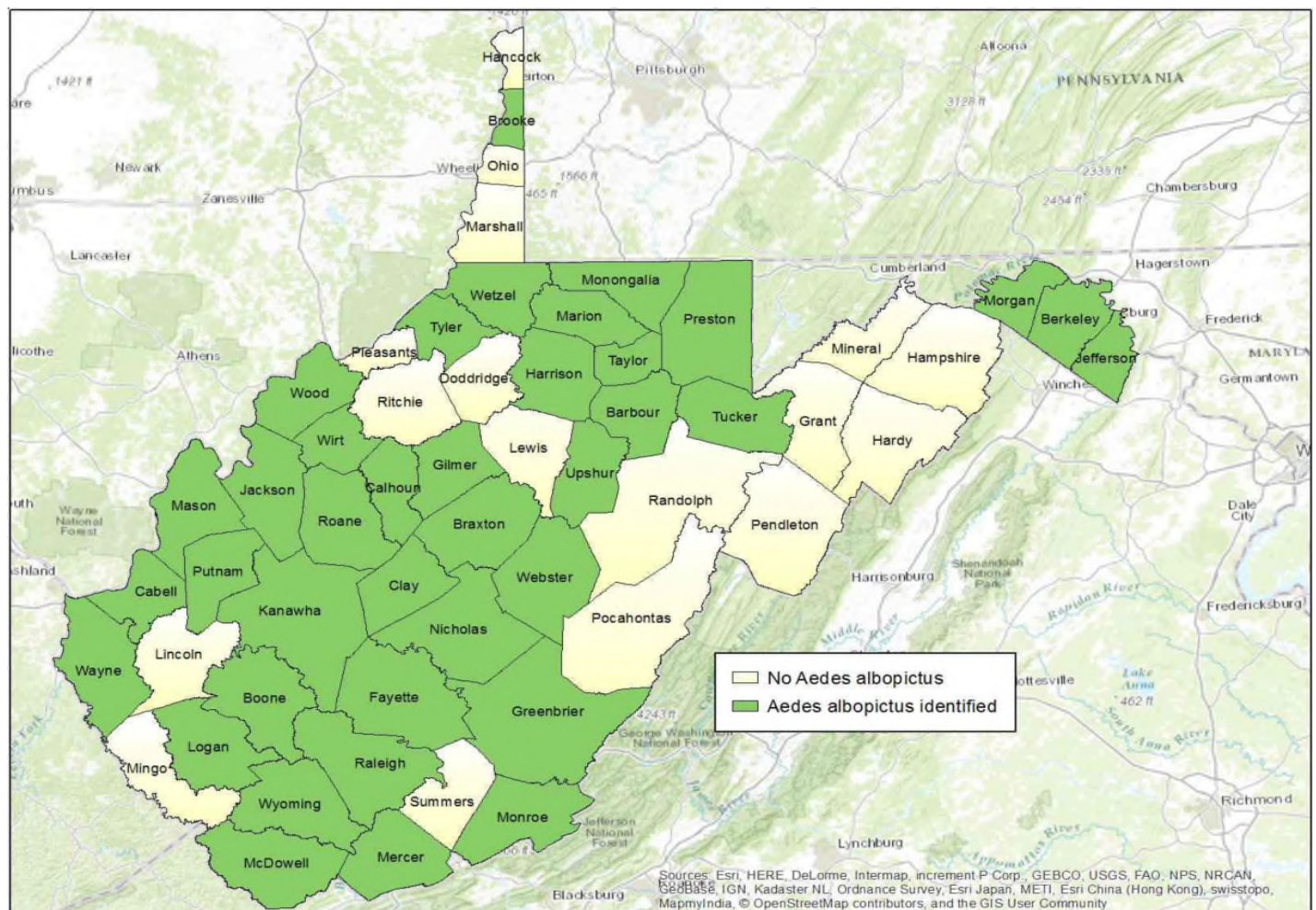
(Zika, continued from page 4)

transmission cycle, the Zika virus is transmitted between a competent mosquito vector and a viable primate. A competent mosquito vector drinks blood from an infected primate, the mosquito vector becomes infected, and then the infected mosquito transmits the virus to another healthy primate during blood-feeding. The transmission principles are similar whether it is a sylvatic (jungle) transmission cycle in African forests involving *Aedes africanus* mosquitoes and rhesus monkeys or an epidemic (urban) transmission cycle in Brazilian cities involving *Aedes aegypti* and humans. Competent mosquito vectors of Zika virus in the continental United States include the Asian tiger mosquito (*Aedes albopictus*) and the yellow fever mosquito (*Aedes aegypti*).

Although *Ae. aegypti* has not been recorded in West Virginia, this mosquito species has been found in central Kentucky, southwestern Ohio, northern and eastern

Virginia, Washington D. C., and eastern Maryland. *Aedes albopictus* has been identified in southeastern United States north into Illinois, Ohio, Pennsylvania, and the New England Coast. Most West Virginia counties have *Ae. albopictus* records (see map below). Therefore, local transmission in West Virginia is possible if a Zika virus infected individual and *Ae. albopictus* mosquito came into contact with each other. The anthrophilic tendencies of *Ae. albopictus* encourages transmission of diseases to humans. *Aedes albopictus* will feed on human blood, lay its eggs in natural and artificial containers near human habitat, enter human dwellings, and remain active during the daytime (especially during the early evening hours). And *Ae. albopictus* will feed on a host more than once, increasing the chances of successful Zika virus transmission.

To find out more about Zika virus, visit the West Virginia Division of Infectious Epidemiology's Zika virus homepage at <http://www.zikawv.org>. ☒



West Virginia Infectious Disease Outbreak Report

January - March 2016

Introduction

In West Virginia, outbreaks are immediately reportable to Local Health Department (LHDs), regardless of setting, as per Reportable Disease Rule 64CS7. LHDs, in collaboration with DHHR's Bureau for Public Health, Division of Infectious Disease Epidemiology (DIDE), investigate all reported outbreaks. DIDE provides outbreak surveillance reports on a monthly and annual basis, and upon request. This report provides a brief description of confirmed outbreaks during the first quarter of 2016. All data provided are provisional.

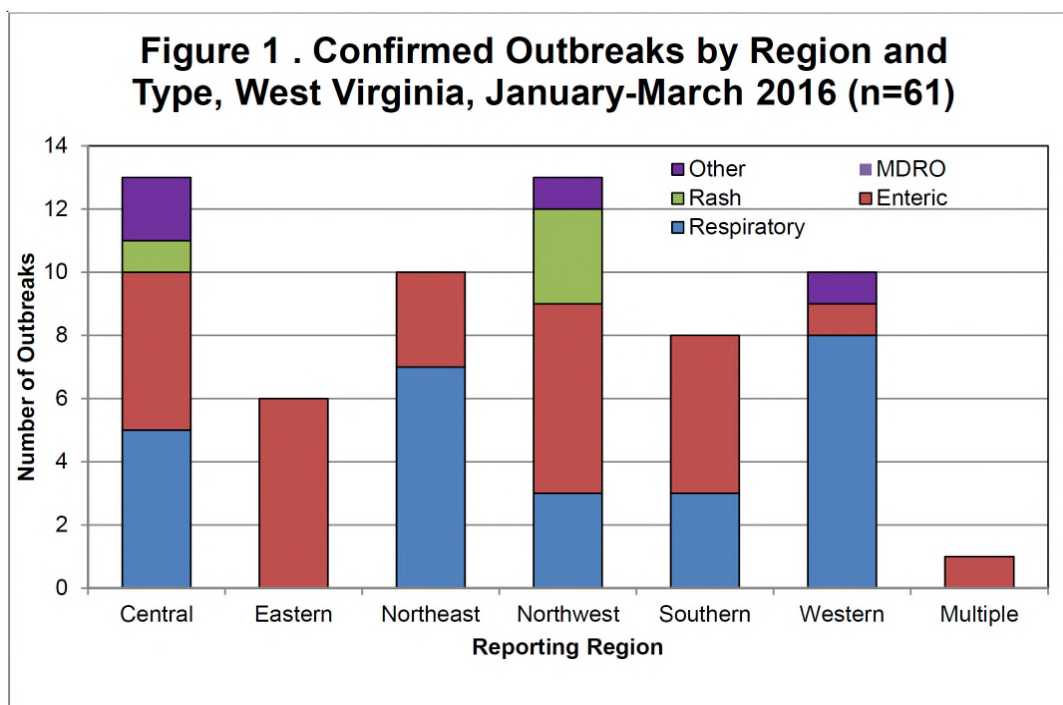
Methods

Data on outbreaks are routinely compiled in Microsoft Excel 2010. Data analyzed for the purpose of this report include information on outbreak type and setting, reporting region, time of reporting to LHDs and DIDE by region, clinical diagnosis, and laboratory information.

Results

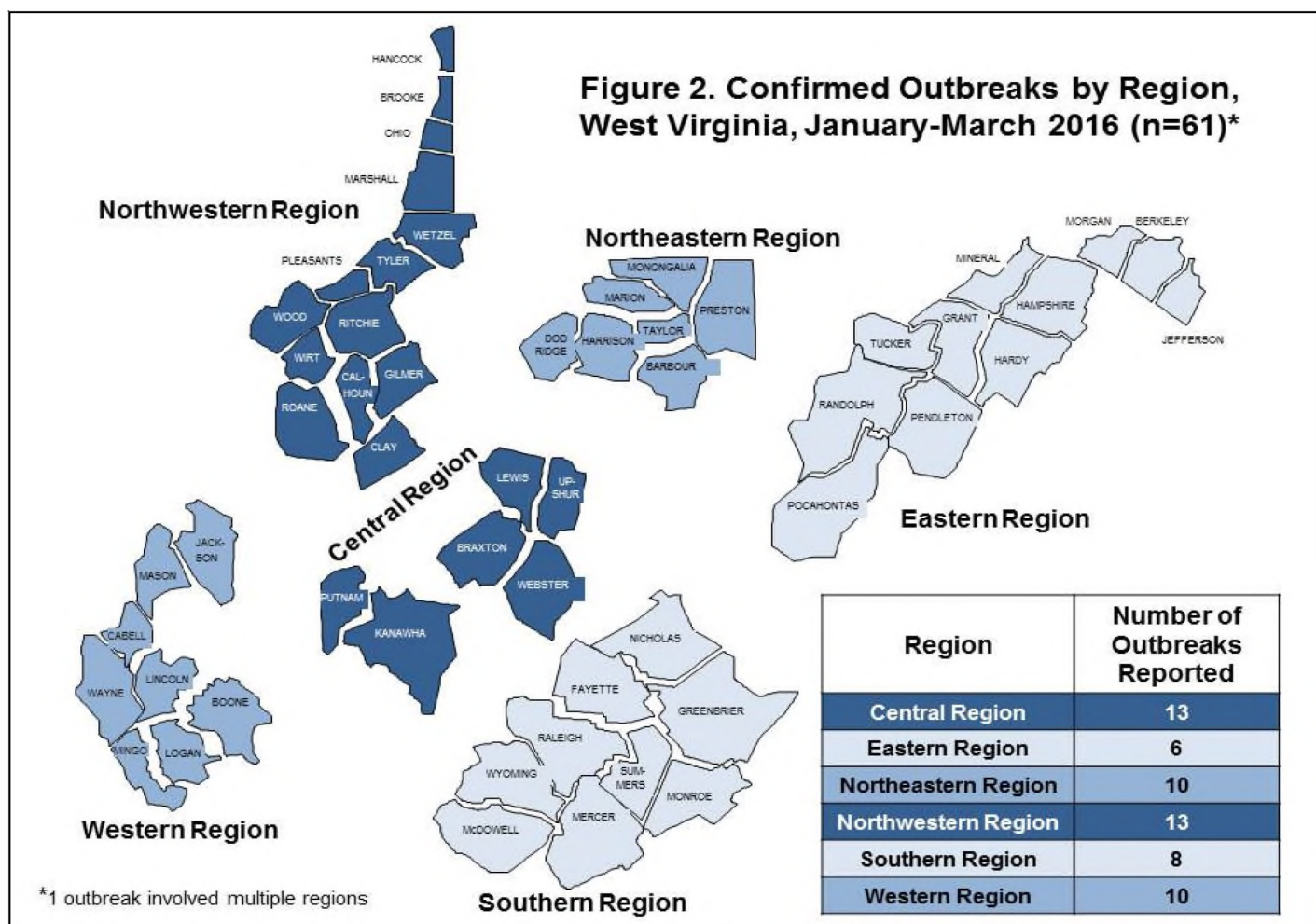
During the months of January, February, and March 2016, there were 65 outbreaks reported in West Virginia. Of the 65 reported outbreaks, 61 (94%) were confirmed as outbreaks or clusters of disease. The remaining 4 were investigated and determined not to be outbreaks. 32 were reported from healthcare facilities, 12 from schools, 8 from daycare centers, 6 from communities, 1 from a church, 1 from a workplace, and 1 was part of a multi-state investigation. Among the 32 healthcare-associated outbreaks reported, 29 (90%) were reported from long-term care facilities (LTCFs), 2 from assisted living facilities and 1 from a hospital.

During this period, all surveillance regions reported outbreaks with a range from 2 to 11 outbreaks per region, as illustrated in Figure 1 below. Figure 2 (page 7) is a map that depicts confirmed outbreaks by region.



(See **Outbreaks**, page 7)

(*Outbreaks*, continued from page 6)



Limitation

Data provided in this report is provisional as some investigations are ongoing.

Conclusions

The majority of healthcare outbreaks were reported from LTCFs. LHDs and LTCFs should review acute respiratory illness, influenza and norovirus outbreak management guidelines available at <http://www.dhhr.wv.gov/oeps/disease/ob/Pages/OutbreakToolkits.aspx>. The toolkits consist of brief guidelines for defining, investigating and managing the outbreak and collecting laboratory specimens. Collecting specimens for testing during respiratory outbreaks is crucial for management of the outbreak and prevention of additional illnesses.

For information on outbreak guidelines or any disease or condition, please visit the Division of Infectious Diseases Epidemiology's website at <http://www.dide.wv.gov>, call 304-558-5358, or call toll-free in West Virginia at 1-800-423-1271. ☒

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